TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
SARANG N DESAI DO

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-15-4009-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 10, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Please see attached EOB, HCFA, and documentation for the above date(s) of service. This is our written request for reconsideration.

On this date of service, you denied claim stating "treating doctor is requiring to submit report indication agreement with MMI/IP." An original appeal for reconsideration was submitted via fax without the treating physician's signature. This has been corrected. We're requesting that you review the attached claims again and process accordingly. These charges are compensable per the injury. I have included in this reconsideration the patient entire medical records, HCFA, and EOB for your review. It is our hope that once you review the medical documentation you will pay the claim."

Amount in Dispute: $50.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ORTHOTEXAS PHYSICIANS AND SURGEIONS provided services to the claimant on the date above date … One year from disputed date 7/15/14 is 7/15/15. The TDI/DWC date stamp lists the received date as 8/10/15 on the requestor's DWC-60 packet, a date greater than one year from 7/15/14. The requestor has waived its right to DWC MDR."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 15, 2014	CPT Code 99455-VR	$50.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - CAC-P12 – Workers ' Compensation Jurisdictional fee schedule adjustment
   - 756 – Treating DR is required to submit report indicating agreement or disagreement with MMI/IR per Rule(s) 130.3 & 134.204
   - 892 – Denied in accordance with DWC Rules and/or medical fee guidelines including current CPT Code descriptions/instructions
   - CAC-W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - CAC-193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 350 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - 724 – No additional payment after a reconsideration of services for information call 1-800-937-6824

Issues

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states:

   Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.

   (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The date of the service in dispute is July 15, 2014. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on August 10, 2015. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	8/28/15 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.